TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PINE CREEK MEDICAL CENTER

MFDR Tracking Number
M4-17-2302-01

MFDR Date Received
March 31, 2017

Respondent Name
MERGED SAFEGUARD INSURANCE CO

Carrier's Austin Representative
Box Number 11

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am in receipt of the denial EOB 'This is a packaged item.'... I am requesting that you re-review the attached supporting documents regarding billing type, and the definition of Medicare B, and remit payment immediately... (Authorization is not required for LABS)."

Amount in Dispute: $41.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier had, in May 2016, reviewed the proposed services in dispute for medical necessity. The Utilization Review Agent issued an adverse determination, finding the services were not medically necessary... The Requestor eventually performed the services anyway. The Carrier's denial of medical necessity continues."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
June 20, 2016	36415, G0477 and G0481	$41.57	$36.86

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - RC 03 – This procedure or supply requires prior authorization or approval
   - 197 – Precertification/authorization/notification absent

Issues

1. Does the respondent's position statement address only the denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Did the requestor obtain preauthorization for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT Codes 36415, G0477 and G0481 rendered on June 20, 2016. The insurance carrier in the position summary states in pertinent part, "The Carrier's denial of medical necessity continues."

   28 Texas Administrative Code §133.307(d)(2)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   The respondent submitted a position summary containing new denial reasons. The additional denial reasons identified on the position summary, "The Utilization Review Agent issued an adverse determination, finding the services were not medically necessary," are not denial reasons raised during the medical bill review process, as they are not indicated on the Explanation of Benefits presented with the DWC060 request. The respondent submitted insufficient information to MFDR to support that the submitted denial reasons raised in their position summary were presented to the requestor or that the requestor had otherwise been informed of these new denial reasons or defenses prior to the date that the request for medical fee dispute resolution was filed with the Division; therefore, the Division concludes that the respondent has waived the right to raise such additional denial reasons or defenses. Any newly raised denial reasons or defenses shall not be considered in this review
2. The requestor seeks reimbursement for CPT Codes 36415, G0477 and G0481 rendered in a facility setting and billed with "bill type 141." 28 Texas Administrative Code §134.600(p)(12) states in pertinent part "(p) Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits."

   Per 28 Texas Administrative Code (TAC) §137.100 (a) states, in pertinent part, that "Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp..."* Health care provided in accordance with the Division treatment guidelines is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a). Review of the 2016 ODG pain chapter under the "Drug testing" finds that drug testing is recommended.

   The division concludes that the services were provided in accordance with the division's treatment guidelines; that the services are presumed reasonable pursuant to 28 Texas Administrative Code §137.100(c), and Labor Code §413.017; and are also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).

   28 Texas Administrative Code §134.600(c) (1) (B) states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

   The Division finds that the insurance carrier's denial reason is not supported. The requestor is therefore entitled to reimbursement for the disputed services.
3. The requestor seeks reimbursement for services rendered in a facility, bill type 141. 28 Texas Administrative Code §134.403 states in pertinent part (h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c).

   28 Texas Administrative Code §134.203(e) states, "The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service."

The maximum allowable reimbursement(MAR) for the services in dispute is 125% of the fee listed for the codes in the 2016 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at http://www.cms.gov. The total MAR is calculated as follows:

- Procedure code 36415, service date June 20, 2016, represents a pathology/laboratory service with reimbursement determined per §134.203(e). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75.

- Procedure code G0477, service date June 20, 2016, represents a pathology/laboratory service with reimbursement determined per §134.203(e). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.36. 125% of this amount is $14.20.

- Procedure code G0481, service date June 20, 2016, represents a pathology/laboratory service with reimbursement determined per §134.203(e). The fee listed for this code in the Medicare Clinical Fee Schedule is $122.99. 125% of this amount is $153.74. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $18.91.

4. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $36.86. As a result, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $36.86.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $36.86 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 12, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.